

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Vilas Carehome Services ARCH/E-ARCH I	CHAPTER 100.1
Address: 94-1254 Kahuaina Street, Waipahu, Hawaii 96797	Inspection Date: March 13, 2024 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> Primary Care Giver (PCG), Household Member (HM) #1 and HM #2 – No current Fieldprint completed for 2024.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have obtained a copy of My,(PCG), HM#1 and HM#2 of our current Fingerprints and is placed inside my care home binder.</p>	<p>04/03/2024</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>, (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> Primary Care Giver (PCG), Household Member (HM) #1 and HM #2 – No current Fieldprint completed for 2024.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again in the future, I will keep a reminder note on my iphone and it will send me an alert one month before myself, SCGs' and HHS', fingerprints expires.</p>	04/03/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> HM #2 – No current physical examination assessment done by physician or advanced practice registered nurse (APRN).</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have obtained a copy of HM#2 of their current physical exam and it's placed inside my care home binder.</p>	<p>04/03/2024</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> HM #2 – No current physical examination assessment done by physician or advanced practice registered nurse (APRN).</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again in the future, I will keep a reminder note on my iphone and it will send me an alert one month before myself, SCGs' and HHs', Physical exam expires.</p>	<p>04/03/2024</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) #1, and HM #2 – No current TB assessment done by physician or advanced practice registered nurse (APRN).</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have obtained a copy of (SCG)#1 and HM#2 of their current Tb clearance and it's placed inside my care home binder.</p>	04/03/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) #1, and HM #2 – No current TB assessment done by physician or advanced practice registered nurse (APRN).</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again in the future, I will keep a reminder note on my iphone and it will send me an alert one month before myself, SCGs' and HHS', Tb clearances expires.</p>	04/03/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>, (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><u>FINDINGS</u> Repeat Deficiency from 2023 annual inspection: The following medications observed unsecured in downstairs refrigerator:</p> <ul style="list-style-type: none"> • Megestrol Acetate 40 mg for SCG #1 • Unlabeled Aranesp recombinant 25 mcg/1mL box with 4 vials • Unlabeled Children's Ibuprofen 60mL <p>SCG removed medications and secured them on site.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 -Physician order 1/10/23 and re-evaluated 4/8/23 for "Acetaminophen 325 mg. 2-tab 1 hour before physical therapy (PT) and every 6 hours PRN [as needed] for pain or temp greater than or equal to 100.0 F." PT notes indicate resident received PT services on 3/26/23 and 5/3/23. Medication Administration Record for those dates did not reflect that PRN Tylenol was offered 1 hour before PT service as ordered by physician.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<p>§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #1 – The following Medication Administration Records (MARs) did not record medications being administered:</p> <ul style="list-style-type: none"> • December 2023 MAR – No initial observed for Famotidine 20mg i.e. evening. Order is to give twice daily. Observed only initialed as given in morning. • January 2024 MAR – Donepezil 10mg and Famotidine 20mg. No initials from 1/1-31/2024 to indicate it was given. • January MAR – Furosemide 20mg. No initials indicating it was being given from 1/1-11/24 before it got discontinued 1/12/24. • February MAR – Famotidine not initialed on 2/29/24 in the evening and evening Seroquel 50 mg ½ tab not initialed as given from 2/1-29/24. 	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #1 – The following Medication Administration Records (MARs) did not record medications being administered:</p> <ul style="list-style-type: none"> • December 2023 MAR – No initial observed for Famotidine 20mg for evening. Order is to give twice daily. Observed only initialed as given in morning. • January 2024 MAR – Donepezil 10mg and Famotidine 20mg. No initials from 1/1-31/2024 to indicate it was given. • January MAR – Furosemide 20mg. No initials indicating it was being given from 1/1-11/24 before it got discontinued 1/12/24. • February MAR – Famotidine not initialed on 2/29/24 in the evening and evening Seroquel 50 mg ½ tab not initialed as given from 2/1-29/24. 	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To Prevent this from happening again in the future, Once a PRN medication is administered to the patient, Myself or SCGs will immediately record it on the Medical Administration Record. I placed a note in my care home binder to remind me of this deficiency and will remind my HHM and SCGs verbally throughout the week.</p>	<p>04/03/2024</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(C) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate;</p> <p><u>FINDINGS</u> Resident #1 and Resident #2 – Signed Policy/Agreement did not have monthly rate for services.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have placed the monthly rate for Resident #1 and Resident#2 inside their Signed Policy/Agreement for the department to view.</p>	04/03/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(C) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate;</p> <p><u>FINDINGS</u> Resident #1 and Resident #2 – Signed Policy/Agreement did not have monthly rate for services.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again in the future, During the signing of the Policy agreement, on the day of admission, I will double check each page for any mistakes or missing information. I will keep a reminder note of this deficiency inside my care home binder.</p>	04/03/2024

Licensee's/Administrator's Signature: anabel vila
Print Name: anabel vila
Date: 04/03/2024